Michigan Association of Health Plans

H.B. 4714
House Committee on Michigan Competitiveness

May 16, 2013

My name is Rick Murdock and I am Executive Director of the Michigan Association of Health Plans. Our association represents 15 health plans serving over 2.5 Michigan citizens in Medicaid, Medicare and Commercial products and 55 business and limited members. Members of MAHP employ nearly 4000 individuals throughout Michigan.

The formal board position of the MAHP is to support all efforts that will provide insurance coverage for Michigan citizens—including support of the Governor's proposal regarding increasing eligibility in the Medicaid program. It is our belief that by providing coverage to all citizens, we can become a healthier population, focus more on preventive services, and avoid the current cost shifting that is taking place due to the number of insured in Michigan.

How we develop and design the program for the new eligibility group is our combined challenge—but it is also an opportunity to begin to re-shape how the Medicaid program functions. In doing so, it is important that we build on the strengths of the Medicaid program and take opportunity where we can find flexibility to institute appropriate changes that make sense for the "non-disabled" adult population. We have included a number of comments on "reform" that are addressed in HB 4714 that I wish to review with the committee. Before we do so, I would like to comment on a few key issues/concerns.

1. First, how do we want to define success? It must be more than simply enrolling additional population. In our view, success should be view as having systemic positive impact throughout our health care system. This may be seen as moderating premium increases for commercial population or the cost of self-insurance; or it may be seen as improving the incidence of chronic disease of our population and having a healthier workforce. Defining success and how it is measured will help shape the design of this program.

2. Second—how do we avoid becoming a "donor state" in health care? As many know, beginning in 2014, the Affordable Care Act will be levying new fees and taxes on the insurance industry—most of which will ultimately be passed on in the premiums that individuals, small

and large businesses and government pay. We know for that there will be a premium tax applied to health insurance of about 2.2% and will gradually increase each year to 3.7 percent by the end of the decade. (Incidentally with some exception, this is a tax applied to Michigan Medicaid Plans as well as commercial plans.) This is a tax that Michigan health insurance companies will pay to the federal government. We also know the federal government will be charging carriers a fee of 3.5% of premiums sold on the insurance exchange. There is also a transitional reinsurance program to be funded by carriers and third party administrators—the cost of which is estimated to be about 1-2% of average premium.

Finally, there is a $3/member/year fee to facilitate the federal administration of the risk adjustment program and fund the new Patient Centered Outcomes Research Institute. There are other factors to influence overall premium costs including benefit design, limits on underwriting and underlying Medicaid cost inflation. The unknown is the effect of competition on price and the impact of the subsidies for those participating on the Exchange. While difficult to calculate at this point, a reasonable estimate of the aggregate payments by Michigan insurance companies due to these new fees to the federal government is between $700 million and $1 billion and will grow each year.

While Michigan taxpayers may see some return in the form of subsidies on the Insurance Exchange—without implementing a Medicaid reform program, Michigan may find itself classified as a "donor" state.

3. Limiting eligibility is likely to be impermissible and not subject to waiver approval. This is perhaps the key item as we go forward. MAHP sought the opinion of experts in Medicaid and the social security act and permissible actions of the federal government. In communication that we have received form the Washington DC office of the firm, Covington & Burling LLP, the opinion is that:

    a. Time limits on coverage are not consistent with the structure of the Medicaid program, and would be found by CMS to violate the Social Security Act.
    b. A belief that CMS would treat a "durational limit" as akin to a "period of ineligibility" for which it would not grant a waiver;
    c. There is no effort by any state to impose time limits on coverage provided to any category of recipient; and a cautionary note,
    d. State would not be able to implement a durational limit on the coverage afforded to any Medicaid recipients without risking the loss of its federal Medicaid funds—and it this context all of Medicaid funding.

While it is clear we can debate the legalities and pursue a waiver with this provision—it is also clear by the nature of the provisions of HB 4714 that this is intended to be a three year program—that is, once the federal match falls below 100% (scheduled for 2017) then the program is no longer in effect. Therefore, operationally it would appear to make more sense to move forward under a three year demonstration project and remove the provision of limiting eligibility—a concept that almost certainly will force a denial of any waiver. Under that context, MAHP has identified the following points for reform:

Recommendations for Reform Under HB 4714

1. **Convert HB 4714 to Focus on a Federal Waiver (Three Year Pilot Program)**

    a. Eliminates any issue/debate on 48 month Eligibility limit and likely CMS denial
    b. Eliminates any issue/debate on State expenditure following 100% federal support
    c. Legislative (and related Waiver Request would then focus solely on reform)

2. **Consumer Choice of Contracted Plan**.
This would be consistent with current practice. The state's enrollment contractor (Maximus/MI ENROLLS) would provide the options in the county of residence for each new eligible person—in the absence of choice, the existing auto assignment algorithm can be used—this is based on more assignments to higher performing health plans.

3. **Consumer Access to Primary Care Provider**.
This would also be consistent with current practice. The State's enrollment contractor (Maximus/MI ENROLLS) receives the provider files –updated monthly—by each contracted health plan. At the time of enrollment, the eligible individual may select a provider or it will be selected for them by the carrier.

4. **Incentives for Healthy Behavior.**
The incentives should be twofold: A series of incentives for the individual, which would include, positive incentives such as gift cards following appropriate utilization or access for preventive visits and potentially the deferral of premium contribution or waiving of copays (Note, under ACA, the provision of preventive services must be first dollar coverage (no copay or deductible).

The health plan incentive can be established via performance contracts that include aggregate targets for behavioral changes—both process (i.e., completion of visits, development of individual wellness contract, as well as health status changes.

Consistent with current Medicaid program, the Medicaid behavioral benefit will likely be administered by the Prepaid Inpatient Health Plans (PIHPs) and there may be opportunity for incentives to be establish via PIHP contracts with the State as well

5. **Progress toward healthy behavior**.
   This may be address in several ways beginning at time of enrollment. The Enrollment Contractor (Maximus/MI ENROLLS) may implement a short health risk appraisal (HRA) to each new eligible person under this program. The results of this information would then be shared with the contracted health plan.

   Secondly, the Contract between the State and Health Plan could require that each new beneficiary complete an individualize wellness care agreement at the time of their initial visit with primary care provider—presumably the personalize wellness plan would address the risk factors affecting chronic disease and be similar to the Governor's 4 x 4 initiative. This individualize plan would be similar to that used in the Community Mental Health Programs and Children Special Health Care Services Program and would be tailored to the individual. It would then be this document and its implementation that would be used for tracking compliance and fulfillment of the agreement. The State could develop a "model" agreement that could be used for this purpose.

6. **Incentives for eligible enrollees who assist the DCH in detecting fraud and abuse in the Medicaid Program.**
   This may be similar to the "whistle blower" provisions used in other state and federal programs and provide cash rewards. (Note any cash award may make the individual ineligible for Medicaid—but then available to access the "exchange".)

7. **Telemedicine.**
   This is consistent with Medicaid policy now....and can be further embellished for this program via a Medicaid policy bulletin.

8. **Premium/Copay (Personal Responsibility)**
   At the time of enrollment, the beneficiary (those above 100% of FPL)could be "charged" a premium—payable within six months—premium would be adjusted for out of pocket maximums not to exceed 5% of total adjusted gross income. For those beneficiaries who satisfactorily comply with the primary

care visit, completion of HRA and individual wellness agreement and related visits—their premium (or copay) contribution would be waived. Those beneficiaries not compliant would be required to be placed in a "beneficiary monitoring program" with more prescriptive management and limits—similar to program being launched this year.

The use of copays should be consistent with the provisions of "value based designed"...that is, be waived to eliminate barriers to desired utilizations and to be imposed related to undesired utilization (e.g., ER use).

9. **Contributions to Health Accounts.**
As part of the capitation payment to the health plan, require the health plan to establish and managed a separate account for each person enrolled under this program. Credits against this account can be made for their Premium contribution—unless waived for meeting individualizes objectives of the personal wellness agreement. The amount in the health account may be used for the individual at the time they leave the program to pay for premiums in the insurance exchange. The incentive being that this account would be available upon departure from the Medicaid program as long as it is used to purchase coverage on the insurance exchange.

10. **Hospital Charges**.
The amount should be set at a level equal to 115% of average Medicare payment rather than Medicare charges.

11. **Capitation Rates for Health Plans**.
While not covered in HB 4714, it is important that the capitated rates be explicitly established as being actuarially sound. Given the responsibilities that will be placed upon carriers, it is important that those costs be part of the actuarial buildup of rates.

12. **Reporting**.
The requirement should begin no earlier than one year after effective date of the implementation of the program. Data requirements from health plans/carriers should be consistent with data elements already required, (HEDIS and Encounter Data Reporting).

13. **Annual Enrollment.**
It is critical for the management of the program that eligibility be determined on an annual basis and similar to current Medicaid program, the

beneficiaries be "locked in" to their health plan following after 90 days. Otherwise the development of wellness agreements, provision of wellness and preventive services, and implementation of a health savings account would be cost prohibitive.

In fact, it would be appropriate to have all of Medicaid eligibility be annually determined and avoid the current "churn" of enrollment. Value based design programs can only be implemented in conjunction with annual enrollment periods—otherwise there is no opportunity for health plans to realize a ROI on their investment in various programs.

Since the contracted health plans for Medicaid already have a relationship with the State's contracted enrollment broker, (Maximus/MI ENROLLS), it would make sense for the website enrollment requirement to be managed by MI ENROLLS, rather than establishing a new system.

14. **Benefits**.

There is some room for flexibility on benefits as long as they are no less than the essential benefit package adopted for Michigan's insurance exchange. The attached chart compares current Medicaid benefits with several other components: state employees, essential package for exchange, and what may be provided under the reform package as we understand the limitations. The changes are in several areas compared to current Medicaid: Transportation and pharmacy. There is also the opportunity to insert limits and additional prior authorizations. The attachment is a version of benefits that we believe would be acceptable.

Health Benefit Comparisons

	MEDICAID	STATE EMPLOYEE PPO	Essential Health Benefits EHB	MEDICAID REFORM
Doctor Visits/Preventive Services	Covered	Covered $10 co-pay	yes	Covered
Prescription Drugs	Covered: Some plans have $1 and $3 co-pay	Covered: three tier co-pay $7, $15, $30	yes	Cover generic, brand name PA
Over the Counter Medicine	Covered	Not Covered	Not Covered	Not Covered
Immunization	Covered	Covered	covered	covered
Inpatient Hospital	Covered 100%	Covered 100% after deductible	covered	Covered, PA
Outpatient Hospital	Covered	Covered 100% after deductible	covered	Covered, PA
Emergency Services	Covered	Covered 100%	covered	Covered, $50 copay
Chiropractic	Covered - some have $1 copay	Covered 90% after deductible	Covered max 30 visit/yr	Covered max 30 visit/yr/PA
Transplants	Covered	Covered 100% after deductible	covered	covered
DME	Covered	Covered 90% after deductible	covered	covered
Prosthetics & Orthotics	Covered	Covered 90% after deductible	covered	covered
Hospice	Covered	Covered 100%	Covered Max 45 day/yr	Covered Max 45 day/yr
Emergency Transportation	Covered	Covered 100% after deductible	covered	Covered-$50 copay
Non-emergency Transportation	Covered	Not Covered	Not covered	Not covered
Maternity Care	Covered	Covered 100% after deductible	covered	covered
Hearing Aid	Covered	Covered 100% after deductible	covered	Covered with PA
Speech Therapy	Covered	Covered 100% after deductible	covered	Covered with PA

Physical/Occupational Therapy	Covered	Covered 100% after deductible	covered	Covered with PA
Medical Tests, Lab X-ray, & Other Imaging Services	Covered	Covered 100% after deductible	covered	Covered with PA
Home Health Care	Covered	Covered 100% after deductible	covered	Covered with PA
Mental Health	20 outpatient visits - other services covered by mental health program	Covered - co-pays vary by service	Covered 20 outpatient visits/yr	covered
Substance Abuse	Covered by substance abuse coordinating agencies	Covered - co-pays vary by service	covered	covered